STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 7/17/18 through 7/19/18. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 7/17/18 through 7/19/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this twelve certified bed facility was eight at the time of the survey. The survey sample consisted of eight current resident reviews and two closed record reviews.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		8/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/24/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 1 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to develop a baseline care plan that included immediate care needs for one of 10 residents in the survey sample. Resident #61's initial care plan failed to include any problems, goals and/or interventions for care of an external urinary catheter used by the resident for incontinence. The findings include:	F 655	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth inthe statement of deficiencies . This POC is prepared and/or executed solely because itis required by the provision of federal and state law. .This POC constitues the facilities credible allegations of compliance for the deficiencies noted. This Plan of Correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 2 Resident #61 was admitted to the facility on 7/12/18 with diagnoses that included sepsis, diabetes, cervical fractures, high blood pressure and chronic kidney disease. The nursing admission assessment dated 7/12/18 assessed Resident #61 as alert and oriented to person, place and time. This assessment listed the resident was admitted using an external urinary catheter due to bladder incontinence. On 7/17/18 at 12:07 p.m., Resident #61 was observed in his room seated in a recliner. Catheter tubing and a urine collection bag were in place beside the chair. The resident stated he routinely used a urinary catheter due to incontinence. Resident #61 clinical record documented no physician's order for a catheter or any care and/or treatment interventions related to catheter use. Resident #61's baseline care plan (initiated 7/13/18) made no mention the resident used an external urinary catheter. The care plan listed the resident had an indwelling Foley catheter due to urinary retention and included no problems, goals and/or interventions regarding the external catheter. On 7/18/18 at 2:00 p.m., the registered nurse unit manager (RN #1) was interviewed about Resident #61's baseline care plan for catheter care. RN #1 stated the resident used an external catheter. RN #1 stated the baseline care plan did not include goals and interventions regarding the external catheter. RN #1 stated the resident had an indwelling Foley catheter during a previous admission but now used only an external catheter.	F 655	is prepared solely because it is required by the provisions of Health and Safety CodeSection 42 CFR 483 et seq.This plan of correction will serve as the facilities credible allegation, the facility is in or will achieve compliance by 8/31/2018. F655-Please cross-reference to F684. A physician's order was obtained for an external urinary catheter for Resident #61 and the comprehensive Person-Centered Care plan for resident #61 was updated to reflect the presence of the external catheter with corresponding goals and interventions to address urinary incontinence. All residents were checked for the presence of a catheter either indwelling or external and compared to their corresponding care plans to ensure accuracy. The Quality Assurance Performance Improvement nurse and/or designee will conduct an audit after all new admissions for a period of 1 month to ensure the 48hr care plan is in place, that the care plan accurately describes resident's problems, goals, and interventions, then one random chart audit quarterly thereafter to reduce the potential for a reoccurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 3 On 7/18/18 at 2:47 p.m., the director of nursing (DON) was interviewed about a baseline care plan for Resident #61's external catheter. The DON stated the resident had an indwelling "Foley" catheter during a previous admission. The DON stated the baseline care plan should have been updated to include the resident's use of an external catheter. These findings were reviewed with the administrator and DON during a meeting on 7/18/18 at 4:00 p.m.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility failed to follow professional standards of care for two of ten residents in the survey sample. 1. Nursing failed to document in the clinical record a nursing note detailing behaviors, pain assessment and non-pharmacological interventions for Resident #1. The resident's clinical record included no mention of the resident's behaviors, pain assessment and non-pharmacological interventions in the clinical notes. 2. The medication Digoxin was administered to	F 658	F658- Third Shift charge nurse was immediately re-educated regarding the importance of documentation of non-pharmacological interventions for behaviors prior to administering medications that require these interventions per Professional Standards of Practice. Nurse two was immediately re-educated on the standard of taking an Apical Pulse prior to the administration of Digoxin. A chart audit was completed of all residents who are taking Digoxin and a clinical task assigned in the chart to remind all nurses with medication administration privileges to document that	8/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 Resident #7 without a prior assessment of the resident's heart rate. The findings include: 1. Resident #1 was admitted to the facility on 06/27/18 with diagnoses that included hypertension (HTN), gastro-esophageal reflux disease (GERD), seizures, fall on the same level, vascular dementia with behavioral disturbance pain, restlessness, agitation, and traumatic subdural and subarachnoid hemorrhage (brain bleed) without loss of conscious. The minimum data set (MDS) dated 07/09/18 assessed Resident #1 with severely impaired cognitive skills. Resident #1's electronic clinical record was reviewed on 7/18/18. During the record review the clinical notes were reviewed, which documented the following Orders - Administration Notes (Medication Administration): 7/18/2018 00:57 Lorazepam Intensol Concentrate 2MG/ML. Give 0.25 ml by mouth every 6 hours as needed for anxiety/restlessness 0.25 ML = 0.5 mg Resident restless, unable to sleep 7/18/2018 02:05 Haldol Concentrate 2MG/ML Give 0.25 ml by mouth every 4 hours as needed for severe agitation/outburst 0.5mg = 0.25M agitation continues to increase 7/18/2018 02:33 Roxanol Solution 20 MG/ML Give 0.25 ml by mouth every 4 hours as needed for air hunger/pain 0.25ML = 5mg Patient remains uncomfortable, agitated. A review of the medication administration report	F 658	they have taken an Apical pulse prior to administering Digoxin. Furthermore, all nurses are to be re-educated on these professional standards at the next nursing meeting scheduled for July 30th and 31st. All new admissions will be reviewed for Digoxin and a triple-check will be conducted to ensure these Professional Standards are followed for those receiving this medication. The Quality Assurance Performance Improvement Nurse and/or designee will audit two charts per week for 1 month followed by 2 charts per quarter to ensure future compliance with non-pharmacological Intervention documentation for Anxiolytics, Anti-Psychotics, and Analgesics. The QAPI Nurse and/or designee will also conduct random medication pass audits for a period of one month of residents who are receiving Digoxin to ensure the professional Standard of taking an Apical pulse prior to administration is followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 5	F 658		

(MAR) was reviewed and matched the administration of the above medications. A review of the clinical notes for 7/18/18 made no mention of Resident #1's behaviors, assessments and non-pharmacological interventions prior to administering the medications.

On 7/18/18 at 7:30 a.m., Resident #1 was observed sleeping in a recliner in the common area on the unit. At 9:30 a.m., Resident #1 was observed continuing to sleep in the recliner in the common area.

On 7/18/18 at 9:50 a.m., CNA #1 was interviewed regarding Resident #1 remaining asleep for this period. CNA #1 stated it was reported in the morning meeting that Resident #1 had a difficult night and only slept about 3 hours. CNA #1 was asked what she meant by a difficult night. CNA #1 stated it was reported Resident #1 was yelling and physically aggressive towards staff overnight. She was disrobing, trying to get up unassisted, pinching and scratching staff. CNA #1 stated it seems she has gotten her days and nights mixed up and her behaviors have increased since she was admitted. She sleeps a lot during the day and is restless in the afternoon and nights. CNA #1 stated I know they will sometimes give her anxiety medication to help her rest. CNA #1 stated I know she is on Hospice we just want her to be comfortable and safe in her last days.

On 7/18/18 at 2:48 p.m., registered nurse unit manager (RN #1) was interviewed regarding the lack of nursing notes in Resident #1's clinical record detailing the resident's behaviors, pain assessment and non-pharmacological interventions. RN#1 stated she was given the report information verbally from the third shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 6	F 658		

charge nurse during the morning meeting. RN #1 stated it was reported to her Resident #1 had a restless night and displayed verbal and physical behaviors including yelling, kicking off the linens, removing her clothes and attempting to get up unassisted and Resident #1 was awake until 3 a.m. RN #1 stated the staff told her they attempted to use repositioning and transfers as non-pharmacological interventions. When asked why the nurse on duty did not document the detailed course of events in the clinical notes including Resident #1's behaviors, pain assessment and non-pharmacological events, RN #1 stated she agreed the clinical record should have had a more detail clinical note.

On 7/19/18 at 8:37 a.m., the director of nursing (DON) provided copies of the pain administration and monitoring tool form. The DON explained this was a paper form that detailed the pain numerical rating and the non-pharmacological interventions. The seventh entry on the form was documented as the following: "7/18/18 at 02:35 a.m., pain-rating 8, location - general, objective signs of pain - restless, screaming. Non-pharmacological interventions included repositioning, soft music, quiet environment, reassurance, and dim lights. Pharmacological interventions - Roxanol." When asked why this form was not provided to the survey team on yesterday and when the form was completed, the DON stated it was a late entry by the charge nurse who was on duty on 7/18/18. The DON stated this form was not a part of the electronic clinical record. The DON stated the nurse was new to the facility and thought the electronic documentation linked with the medication administration was sufficient. RN#1 stated the charge nurse was familiar with hospital documentation guidelines and needed more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 7	F 658		

education on long-term care documentation. The DON was asked to provide copies of the facility's documentation policy. The DON stated she would look for the policy and stated the facility had a "cheat-sheet" for nursing to use.

On 7/19/18 at 10:18 a.m., the DON provided a copy of the facility's "Nursing Duties - All Shifts" document that stated the "charge nurse will make rounds on all residents. Do focused assessments and documentation on skilled residents and high risk residents (residents who had falls; are in end-of-life; needing pain management; have pressure ulcers; have diagnoses of CHF, etc.)" Additionally, the DON provided a copy of the facility's policy titled "Maintaining Clinical Records" (revised 8/1/2016) which states each clinical record shall contain the following: "nurse's notes containing observations made by nursing personnel." The DON stated the expectation was that nursing should have documented the events of 7/18/18 in Resident #1's clinical notes.

The Lippincott Manual of Nursing Practice 10th edition states on page 16 concerning standards of care, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurses's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because the passage of time may lead to a less than accurate recollection of the specific events." Pages 16 and 17 of this reference state, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 8	F 658		

information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record...Failure to communicate or document a significant change in a patient's condition to appropriate professional...Failure to make prompt, accurate entries in a patient's medical record..." (1)

No additional information was provided to the survey team prior to the exit conference on 07/19/18 at 11:15 a.m.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.
2. A medication pass observation was conducted on 7/18/18 at 9:00 a.m. with licensed practical nurse (LPN) #1 administering medications to Resident #7. LPN #1 administered a half tablet of the medication Digoxin 0.125 mg (milligrams) to Resident #7. LPN #1 did not check the resident's apical heart rate or radial pulse rate prior to administration of the Digoxin.

Resident #7's clinical record documented a physician's order for Digoxin .125 mg 1/2 tablet daily for treatment of atrial fibrillation.

On 7/18/18 at 9:45 a.m., LPN #1 was interviewed about checking the resident's heart rate prior to administering Digoxin. LPN #1 stated she did not check a heart rate prior to Digoxin unless ordered by the physician. LPN #1 stated Resident #7 did not have a specific order to check the heart rate prior to Digoxin.

On 7/18/18 at 11:55 a.m., the director of nursing (DON) was interviewed about the Digoxin administration during the medication pass

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 9	F 658		

observation. The DON stated it was a standard practice to check the apical pulse prior to giving Digoxin.

The facility's drug reference titled Nursing 2019 Drug Handbook on pages 455 through 459 describes Digoxin as a cardiac glycoside used for the treatment of heart failure and atrial fibrillation. Page 457 of this reference stated, "Before giving drug, take apical-radial pulse for 1 minute, Record and notify prescriber of significant changes (sudden increase or decrease in pulse rate, pulse deficit, irregular beats and, particularly, regularization of a previous irregular rhythm..." Page 459 of this reference stated, "Monitor patient for toxicity. Toxic effect on the heart may be life-threatening and require immediate attention...Alert: Excessively slow pulse rate (60 beats/minute [bpm] or less) may be a sign of digitalis toxicity. Withhold drug and notify prescriber..." (1)

The facility's policy titled High Alert Medications (revised 11/5/15) stated, "It is our policy to employ special (safety) precautions for the overall management and standardization of high alert medications to include ordering, storage, dispensing and administration due to significant patient/resident injury resulting from errors associated with the use of these medications..." This policy defined high alert medications as, "Drugs that have an increased risk of causing significant patient harm when used in error. Drugs identified as high alert medications in this organization are...Cardiac glycosides (digoxin)...Digoxin has an extremely narrow therapeutic index. Toxicity or sub-therapeutic effect can be fatal..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 10 These findings were reviewed with the administrator and DON during a meeting on 7/18/18 at 12:00 p.m. (1) Woods, Anne Dabrow. Nursing 2019 Drug Handbook. Philadelphia: Wolters Kluwer, 2019.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to obtain physician orders for use of an external urinary catheter for one of 10 residents in the survey sample. Resident #61, admitted with an external urinary catheter for incontinence, had no physician orders for care and treatment of the catheter. The findings include: Resident #61 was admitted to the facility on 7/12/18 with diagnoses that included sepsis, diabetes, cervical fractures, high blood pressure and chronic kidney disease. The nursing admission assessment dated 7/12/18 assessed Resident #61 as alert and oriented to person,	F 684	F684-Please cross-reference to F655. A physician's order was obtained for an external urinary catheter for Resident #61 and the comprehensive Person-Centered Care plan for resident #61 was updated to reflect the presence of the external catheter with corresponding goals and interventions to address urinary incontinence. All residents were checked for the presence of a catheter either indwelling or external and compared to their corresponding care plans to ensure accuracy. All Nurses will be re-educated on the importance of updating care plans by comprehensively reviewing problems, goals, and interventions to assure accuracy. The Quality Assurance Performance Improvement nurse and/or	7/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 place and time. This assessment listed the resident was admitted using an external urinary catheter due to bladder incontinence. On 7/17/18 at 12:07 p.m., Resident #61 was observed in his room seated in a recliner. Catheter tubing and a urine collection bag were in place beside the chair. The resident stated he routinely used a urinary catheter due to incontinence. Resident #61's clinical record documented no physician's order for a urinary catheter or any care and/or treatment interventions related to the catheter. Resident #61's baseline care plan (initiated 7/13/18) made no mention the resident used an external urinary catheter. The care plan listed the resident had an indwelling Foley catheter due to urinary retention. The care plan referred to the resident's treatment administration record (TAR) for specific care orders regarding changing of the catheter tubing and the urine collection bag. Resident #61's TAR for July 2018 had no entries regarding the external catheter and no record of any care and/or treatment implemented regarding the catheter. On 7/18/18 at 1:55 p.m., the licensed practical nurse (LPN #1) caring for Resident #61 was interviewed about orders and care for the external catheter. LPN #1 stated she thought Resident #62 had an indwelling "Foley" catheter. LPN #1 reviewed the resident's clinical record and stated she did not see any physician's order for a urinary catheter and the TAR had no catheter care orders listed. On 7/18/18 at 2:00 p.m., the registered nurse unit manager (RN #1) was interviewed about	F 684	designee will conduct an audit after all new admissions for a period of 1 month then one random chart audit quarterly thereafter to reduce the potential for a reoccurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 Resident #61's catheter. RN #1 stated there should be a physician's order for care of the external catheter and the required catheter care should have been listed on the TAR. RN #1 stated because there was no order for the catheter, no care instructions were added to the TAR. On 7/18/18 at 2:47 p.m., the director of nursing (DON) was interviewed about no care orders or plan of care regarding Resident #61's urinary catheter. The DON stated daily care was provided but was not captured on the TAR. The DON stated because there was no physician order for the catheter, the catheter care was not added to the TAR. These findings were reviewed with the administrator and DON during a meeting on 7/18/18 at 4:00 p.m.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to administer oxygen as ordered by the physician for one of 10 residents in the survey	F 695	F695- A comprehensive assessment including vitals was conducted for Resident #5 to ensure no ill effects from the additional 1.5 (lpm) of Oxygen were	8/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 13 sample. Oxygen was administered to Resident #5 at 3 to 4 liters per minute (lpm) when the physician ordered rate was 1 to 2 liters per minute. The findings include: Resident #5 was admitted to the facility on 6/11/18 with diagnoses that included COPD (chronic obstructive pulmonary disease), anemia, heart failure, diabetes and high blood pressure. The minimum data set (MDS) dated 6/25/18 assessed Resident #5 with moderately impaired cognitive skills. On 7/17/18 at 11:50 a.m., Resident #5 was observed in her room with oxygen administered from a concentrator at 4 liters per minute. On 7/18/18 at 10:29 a.m., Resident #5 was observed again with oxygen in use with the concentrator set midway between 3 and 4 lpm. The resident was asked about her oxygen use at this time. Resident #5 stated she used the oxygen "most of the time" because she got a "stuffy feeling" without it. Resident #5's clinical record documented a physician's order dated 6/12/18 for oxygen to be administered at 1 to 2 liters per minute as needed to keep the resident's oxygen saturation level above 90%. The resident's plan of care (revised 6/29/18) listed the resident had shortness of breath and was at risk for breathing difficulties due to history of respiratory failure, heart failure and anemia. Interventions to prevent breathing complications	F 695	realized. All clinical staff have been re-educated to monitor oxygen concentrators every two hours with rounds to ensure no adjustments have been made away from physician orders. All residents receiving oxygen therapy will have an additional task assigned to POC (Point of Care) documentation software to ensure the correct O2 levels are administered moving forward. The Quality Assurance Performance Improvement Nurse and/or designee will conduct weekly rounds for a period of one month then quarterly thereafter to ensure accuracy of O2 level adjustment on oxygen administration equipment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 14 included, "Oxygen: 1 - 2 Liters [per minute] via NC [nasal cannula] to keep SATS [saturations] greater than 90%..." On 7/18/18 at 1:51 p.m., the licensed practical nurse (LPN #1) caring for Resident #5 was interviewed about the oxygen administration rate. Accompanied by LPN #1, Resident #5's oxygen concentrator setting was observed. The administration rate was set between 3 and 4 lpm. LPN #1 reviewed the resident's clinical record and stated the oxygen rate was ordered at 1 to 2 lpm. These findings were reviewed with the administrator and director of nursing during a meeting on 7/18/18 at 4:00 p.m.	F 695		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		8/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 15 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 16 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 10 residents in the survey sample. Resident #2's electronic health record failed to indicate the resident's "Do Not Resuscitate" status. The resident's current physician order summary did not include the "Do Not Resuscitate" order. The findings include: Resident #2 was admitted to the facility on 6/20/18 with a re-admission on 6/28/18. Diagnoses for Resident #2 included sacral fracture, COPD (chronic obstructive pulmonary disease), atrial fibrillation, high blood pressure and insomnia. The minimum data set (MDS) dated 7/5/18 assessed Resident #2 with moderately impaired cognitive skills. Resident #2's electronic health record was reviewed on 7/17/18 at 4:00 p.m. The document tab of the record included a scanned copy of a Durable Do Not Resuscitate Order for Resident #2 dated 6/20/18. The electronic health record did not display the do not resuscitate status on the resident information screen. The current list of physician orders made no mention of the	F 842	F842- Resident #2 Physician was immediately contacted to secure order for current code status. Admitting nurse was immediately re-educated on importance of obtaining code-status order upon admission to health center. All clinical staff are to be re-educated on this standard also at the next nursing meeting scheduled for July 30th and 31st. The Quality Assurance Performance Improvement Nurse and/or designee will conduct random chart audits once per week for a period of one month followed by one per quarter to ensure future compliance with this standard.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 17 resident's DNR (do not resuscitate) order. On 7/18/18 at 1:49 p.m., the licensed practical nurse (LPN #1) caring for Resident #2 was interviewed about the resident's resuscitation status. LPN #1 looked at the electronic clinical record and stated she thought the resident was a "full code," indicating the need for resuscitation interventions in case of cardiac or pulmonary arrest. LPN #1 stated the code status was usually indicated on the resident information screen and no code status was displayed for Resident #2. LPN #1 reviewed the current physician orders and stated she did not see an order regarding the resident's resuscitation status. On 7/18/18 at 2:03 p.m., the registered nurse unit manager (RN #1) was interviewed about Resident #2's resuscitation status. RN #1 reviewed the resident's paper chart and stated the resident was a "DNR." RN #1 stated it was standard practice to get an order regarding resuscitations status upon admission. RN #1 stated Resident #2 was re-admitted on 6/28/18 and the previous DNR order was left off the physician order list. RN #1 stated the physician orders and electronic record were supposed to reflect the resident's DNR order. These findings were reviewed with the administrator and director of nursing during a meeting on 7/18/18 at 4:00 p.m.	F 842		